# Application for Medicare Part B Premium Assistance for Qualifying Individuals (QI)

Date Received in DHHS Office:

For DHHS use only

## 1. TELL US ABOUT YOURSELF (THE PERSON APPLYING FOR HELP IN PAYING THE MEDICARE PREMIUM)

| **Name** (First, Middle Initial, Last): | **Social Security Number**: | **Medicare Number:** | **Date of Birth**: |
|---|---|---|---|
| | | | |

| **Address where you get mail** (include apartment number) **City** **State** **Zip Code** | **County**: |
|---|---|
| | |
| **Home Address** (if not the same as your mailing address) **City** **State** **Zip Code** | **Telephone Number**: ( ) |
| | |

| **Sex:** | **Marital Status**: | **What language do you use most?** | **Race** | |
|---|---|---|---|---|
| ☐ Female | ☐ Single ☐ Widowed | ☐ English ☐ Spanish ☐ Chinese | | ☐ White ☐ African American ☐ Hispanic |
| ☐ Male | ☐ Married ☐ Separated | ☐ Russian ☐ Sign Language ☐ Vietnamese | | ☐ Cuban ☐ Puerto Rican ☐ Mexican |
| | ☐ Divorced | ☐ Other: | | ☐ Native American/American Indian ☐ Asian American |
| | | | | ☐ Refugee Entrant ☐ Other: |

## 2. IF YOU ARE MARRIED AND LIVING TOGETHER, TELL US ABOUT YOUR SPOUSE

| **Name** (First, Middle Initial, Last): | **Social Security Number**: | **Medicare Number:** | **Date of Birth**: |
|---|---|---|---|
| | | | |

| **Sex:** ☐Female ☐ Male | **Race** | ☐ White ☐ African American ☐ Hispanic ☐ Cuban ☐ Puerto Rican ☐ Mexican ☐ Asian American<br>☐ Native American/American Indian ☐ Refugee Entrant ☐ Other: |
|---|---|---|

## 3. IF YOUR CHILD UNDER 22 LIVES WITH YOU, GIVE US THIS INFORMATION.

| Child's Name | Birth Date | Social Security Number *(Optional)* | Child's Income | How often received? |
|---|---|---|---|---|
| | | | | |
| | | | | |

**4. DO YOU OR YOUR SPOUSE HAVE INCOME FROM ANY SOURCE LISTED BELOW? Check "Yes" or "No" for each question.**

(Please include copies of checks, check stubs, letters, or other proof of income)

| Income Source | Yourself | | | | Spouse | | | |
|---|---|---|---|---|---|---|---|---|
| | Yes | No | How Much? | How often received | Yes | No | How Much? | How often received |
| Social Security | | | | | | | | |
| Veteran's Benefits | | | | | | | | |
| Employment | | | | | | | | |
| Income from an Annuity or retirement fund | | | | | | | | |
| Money from friends or relatives | | | | | | | | |
| Interest, Dividends | | | | | | | | |
| Income from a Trust *(Send a copy of the trust)* | | | | | | | | |
| Other *(Identify)* | | | | | | | | |

**5. DOES THE EQUITY VALUE OF ALL YOUR ASSETS ADD UP TO MORE THAN $6,600 IF YOU ARE SINGLE, OR $9,910 IF YOU ARE MARRIED AND LIVING WITH YOUR SPOUSE?** Do not count the value of the home you live in or up to two vehicles.

☐ **Yes, my assets are over $6,600 (Single) or $9,910 (Married)**
☐ **No, my assets are less than $6,600 (Single) or $9,910 (Married)**

Assets are things that you own, such as cars, boats, trailers, non-homestead property, checking and savings accounts, cash, and CDs. Equity value is how much something is worth minus any money owed on it. (For example, you have a vehicle that is valued at $5,000, and you owe $2,000, the equity value is $3,000.)

**6. APPLICANT AND/OR AUTHORIZED REPRESENTATIVE MUST READ RIGHTS AND RESPONSIBILITIES AND SIGN BELOW.**

(When possible, both the Applicant and the Authorized Representative should sign.)

Signature of Applicant: _____ Date: _____

Signature of Authorized Representative (AR): _____ Date: _____

AR's Address: _____ Phone Number: _____

## Rights and Responsibilities

1. I know that the information I have given is confidential. I understand that, except as specified below, information including medical information can be released only for purposes directly related to the administration of the Healthy Connections Program. At times, the Department of Health and Human Services (DHHS) will release information to organizations that they hire to carry out specific purposes, but those organizations will have agreed to be bound by the same guidelines for release of information. Furthermore, I know that personal health information I provide or that is later gathered by DHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

   a. I know that, in accordance with the federal rules governing the Healthy Connections Program, any information I have given must be reviewed and verified by DHHS staff. Also, I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permission by me is needed to get verification or other information.

   b. I know that, in accordance with the federal rules governing the Healthy Connections Program, DHHS staff must provide information about my family and me to a computer system called the State Income and Eligibility Verification System (SIEVS). This computer system allows DHHS to compare the information about my family and me with information from other agencies, and allows other states (including agencies from other states) and federal agencies to use information gathered on this application to verify eligibility and determine benefit amounts for their programs. Other agencies include, but are not limited to, the Internal Revenue Service, Social Security Administration, and Employment Security Commission, other states' Medical Assistance programs, and the TANF and Food Stamp agency (Department of Social Services (DSS), in this state). Immigration status will be verified with the Department of Homeland Security (DHS).

   c. I know that, unless I specify otherwise, information about my family and me may be shared by DHHS for the purpose of making a proper referral of my case to other sources of services or treatment, in accordance with federal and state law. When possible, I, or my responsible party, will be asked to agree. However, I further understand that in the case of mandatory reporting, DHHS must report, and cannot honor my specification to the contrary.

   d. I know that, unless I specifically ask not to be included, information about services (including medical services) provided to my family and me will be stored in a data warehouse operated by the South Carolina Budget and Control Board, Office of Research and Statistics, and that other state agencies or medical providers that provide services to me or my family will be allowed to access that information in order to be sure that services provided to my family and me are sufficient and necessary.

2. I know that my Social Security Number, which I am required to provide, under §1137(a) (1) of the Social Security Act [42 U.S.C. 1320b-7(a) (1)], may be used or released in connection with the exceptions in Item 1, above.

3. I know that according to Federal law and US Department of Health and Human Services (HHS) policy, DHHS cannot discriminate on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, I should contact HHS by writing to The HHS Director, Office of Civil Rights, Room 506F, 200 Independence Avenue, SW, Washington, DC 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.

4. I know that the Healthy Connections Program does not pay medical expenses that a third party, such as a private health insurance company or someone who injures me, is supposed to pay. I therefore assign and give my rights to any payments from a liable third party to the DHHS up to the payment amount that Healthy Connections has made for my medical care. This assignment applies to any of my minor children who may be injured. These payments may include payments from hospital and health insurance policies or payments received as a settlement from an accident.

5. I must report any address changes.

6. I know that I may request a hearing if I believe an error has been made in processing my application.